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In The

Supreme Court of the United States

BROCKTON HOSPITAL,
Petitioner

v.

NATIONAL LABOR RELATIONS BOARD and
MASSACHUSETTS NURSES ASSOCIATION

On Petition For Writ Of Certiorari
To The United States Court Of Appeals For The
District Of Columbia Circuit

PETITIONER'S REPLY BRIEF TO RESPONDENT'S BRIEF IN OPPOSITION

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RULES 14.1 AND 29.6 STATEMENT

Petitioner is Brockton Hospital, a non-profit corporation under Massachusetts law which operates an acute-care community hospital in Brockton, Massachusetts. The National Labor Relations Board is the federal governmental agency charged with enforcement of the National Labor Relations Act, 29 U.S.C. sec. 150 et seq. (the "Act"). The Massachusetts Nurses Association is a labor organization under the Act and representative of the registered nurses employed by the Petitioner; it was the charging party before the Board and an intervenor in the Circuit Court below.

Petitioner has no parent companies nor does any publicly held company own more than 10% of petitioner's stock.

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442 U.S. 773, 99 S.Ct. 2598 (1979) Passim

PETITIONER'S REPLY TO THE BOARD'S OPPOSITION

1. The So-Called "Safe Care Campaign"

The Board suggests in its brief that the purpose of the so-called "Safe Care Campaign" literature distribution at the entrances to Brockton Hospital was to prepare for contract negotiations which would not even come up for another six months. Opp. Brf. At 3. Indeed, that is what MNA witnesses testified to, testimony directly contrary to the MNA's own internal documents which were in evidence but ignored by the ALJ, the Board, and the lower Court. For example, J.App. , Vol. II at 845, a document drafted and distributed by the MNA, reads in relevant part:

> . . . the Massachusetts Nurses Association has launched the "Statewide Campaign for Safe Care," involving concerned nurses and consumer advocates from throughout the Commonwealth. The goal of the campaign is to inform consumers and policymakers about how staff changes in hospitals, long term care facilities and other health care settings are limiting patient's [sic] access to quality nursing care that is essential to adequate prevention, recovery and treatment of illness and injury.

The Union was elated that the literature distribution "became very visible to the public eye." J.App., Vol. II at 845-908.

The Board also suggests that the literature was distributed only at the three entrances, again contrary to the record evidence. Opp. Brf. at 3. Off-duty nurses

distributed multiple copies of the literature to their co-workers, to nurses' mailboxes and in the Hospital cafeteria. J.App., Vol. I at 239, 244-245; Vol. II at 1048-49. Hospital personnel found the literature in various locations throughout the Hospital over the course of the MNA's campaign, a fact also ignored by the ALJ, the Board and the lower Court. A 22-23; J.App., Vol. I at 430, 539-540. The Hospital had to develop and implement a communications plan to share with patients what was going on because patients and families had been asking what was going on. J.App., Vol. I at 430.

It is nonsense that this activity was to prepare for negotiations and nonsense that it was not in context disparaging of the Hospital. Any nurse arriving for work being handed a copy of material with headlines about patients dying is not going to associate that material with collective bargaining or any protected activity.

Moreover, even if no patient was ever handed one of the handouts, patients and families were asking questions about what was going on, and the union itself was happy that their activities "became very visible to the public eye". J.App., Vol. II at 1050, 1052.

2. "Work" Areas and "Immediate Patient Care" Areas

One aspect of the Hospital's Petition is the Board's finding that its distribution and solicitation policy is overbroad because it barred such activity in "halls and corridors used by patients." Opp.Brf. at 5. The Board's rationale was that some of those areas may not meet the Board's narrow definitions of either an "immediate patient care area" or a "work area". *Id.* The Board fails to explain, however, how corridors regularly used by patients are not inherently a work area in an acute care hospital.

The Hospital suggested a rule making presumptively lawful a ban on solicitation and distribution in areas "where patients, their families, and visitors spend a substantial amount of time." *Id.* This does not appear unreasonable in an acute care hospital setting generally, but particularly where as previously noted patients are sicker and stays are shorter than they were in 1978. Pet. at 6-8. The Board, after all, does not run a Hospital.

The Hospital's suggested rule certainly appears more consistent with this Court's admonition in *NLRB v. Baptist Hospital, Inc.*, 442 U.S. 773, 790 n. 16, 99 S.Ct. 2598 (1979):

> The Board, in reviewing the scope and application of its presumption, should take into account that a modern hospital houses a complex array of facilities and techniques for patient care and therapy that defy simple classification. Patients not undergoing treatment at the moment are cared for in a variety of settings -- recovery rooms, intensive-care units, patients' rooms, wards, sitting rooms, and even corridors, where patients are often encouraged to walk, or to visit with their families.[1]

In fact, the majority in *Baptist Hospital* stated that

> the experience to date raises serious doubts as to whether the Board's interpretation of its present presumption adequately takes into account the medical practices and methods of treatment incident to the delivery of patient-care services in a modern hospital.

3. "Actual" Versus "Likelihood" Of Harm To Patients

According to this Court, a hospital bears the burden of proving only that "solicitation *may* adversely affect patients." *Baptist Hospital.*, 442 U.S. at 782 (emphasis supplied). This standard does not require the Hospital to wait until a patient suffers actual harm or is actually handed a copy of the distribution. Yet, the standard the Hospital effectively was held to in this case was having to prove actual harm to patients, regardless of the rhetorical legerdemain employed by the lower Court and the Board in its Opposition Brief.

The evidence was that there was distribution at three entrances, to employee mailboxes, to employees in the cafeteria, and that distributed materials were found discarded in areas accessible to patients and families. The evidence was also that the distribution generated so much interest on the part of patients and families that the Hospital was forced to develop and implement a communications plan to deal with it.

Yet with this level of distribution and patient and public awareness on the record, the lower Court somehow found that the Hospital had not demonstrated a likelihood of harm because there was no evidence that any patient actually saw or received the material. If this evidence does not demonstrate a likelihood of harm, then it is because the actual standard applied was higher, that of actual harm.

Baptist Hospital, 442 U.S. at 790.

The Petitioner certainly agrees, and this statement unfortunately is as true today as it was in 1978.

There is no way the Hospital could adduce more proof of a likelihood of harm without showing actual receipt by patients of the distributions. But why should the Hospital have to wait for actual receipt? Why is any decent Hospital administrator going to stand around and wait until a patient is injured or harmed before banning the distribution of literature with headlines about people dying in hospitals? The Board's and lower Court's position simply is absurd and ignores this Court's discussion in *Baptist Hospital*.

Finally, as noted above, even if no patient was ever handed one of the handouts, patients and families were asking questions about what was going on, and the union itself was happy that their activities "became very visible to the public eye". J.App., Vol. II at 1050, 1052.

Conclusion

For all the foregoing reasons, Petitioner respectfully requests that its petition for a writ of certiorari be granted.

Respectfully submitted.

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